Obstetrics

VBAC

-A G2P1 at 39 with a previous c-section:

- **a. How would you counsel her regarding delivery?**
- **b. How would you ripen her cervix?**
- **c. She's 4 cm. How would you induce?**

-A patient choosing a VBAC is in labor at 38 week with recurrent severe variable decelerations.

- **a. What is your differential diagnosis?**
- **b. How would you manage?**
- **c. How would you induce a VBAC?**
- **d. How would you ripen the cervix?**

-How do you select who is a good candidate for VBAC?
-What are the contraindications to VBAC?
-What is the difference in counseling between VBAC and TOLAC
-What would you do if a patient requesting a VBAC did not go into labor?

The concept of **TOLAC (Trial Of Labor After Caesarean**) is replacing VBAC, in recognition that, particularly in women with a prior Caesarean due to labor dystocia, the aggregate maternal/fetal risk of an unsuccessful VBAC may exceed that of an elective repeat Caesarean. It is most important to emphasize at the outset that the choice of delivery route should be individualized rather than mandated and to acknowledge that both VBAC and repeat Caesarean delivery do carry specific risks for both mother and fetus. Here we will discuss the recommended criteria for selection of patients for VBAC, the contraindications to VBAC, and other factors presenting an increased specific risk of uterine rupture during trial of labor and VBAC. Cervical ripening cautions appear at the end of this discussion.

Criteria for selecting a patient as a candidate for VBAC:

1. Documentation that the previous uterine incision is either a low segment transverse incision or a low vertical incision **which does not extend to the fundus.**
2. One prior Caesarean delivery
3. Patients with two prior Caesareans may be considered for VBAC (this is no longer a contra-indication) but there is a slightly increased likelihood of failure.
3. Clinically adequate pelvis for vaginal delivery by pelvimetry.
4. No other prior uterine scars or prior uterine trauma.
5. Physician must be in attendance for the entire labor and must be capable of performing an emergency Caesarean delivery if necessary.
6. Availability of facilities and staff, including anesthetist, for performance of emergency Caesarean delivery if necessary.

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